Arlington Board of Health

Seasonal Flu Vaccination for *Children*
2015-2016 Insurance Information Form

☐ S
☐ M

******This form is only for residents ages 18 years and younger******

Information about the person receiving the vaccine (please print): *Required Fields

Name: (Last, First, MI)* Please use full first name	Date of Birth: * _____ _____ _____ Month Day Year	Age*	Gender: (Circle)* Male Female
Street Address:*			
City:*	State:*	Zip:*	Phone:* ( )

Insurance Information: *Include the whole member ID number and any letters that are part of that number*

Primary Insurance Provider:*	Member ID #:*_____ Group Id #: _____ (If applicable)	**Place a copy of the front of your insurance card here.**
Name of Secondary Insurance:	Member ID #:*_____ Group Id #: _____ (If applicable)	

If person receiving vaccine is not the subscriber, please complete the following:

Subscriber's Name: (Last, First, MI)*	Subscriber's Date of Birth: * _____ _____ _____ Month Day Year	Gender: (Circle)* Male Female
Subscriber's Street Address:* (Only if different from address above)		
City:*	State:* Zip: *	Phone:* ( )
Patient Relationship to Subscriber: (circle)* Spouse Child Other:_____		

My child:

- ☐ Is enrolled in Medicaid (includes MassHealth and HMOs etc. if enrolled through Medicaid)
- ☐ Does not have health insurance
- ☐ Is American Indian (Native American) or Alaska Native
- ☐ Has health insurance and is not American Indian (Native American) or Alaska Native

I give permission for my child to receive the vaccine, for vaccination information to be included in the Massachusetts Immunization Information System (MIIS)*, and for my insurance company to be billed. **Please see reverse side for MIIS details.*

X _____ Date: _____
(Signature of parent/guardian)

******For Clinic/Office Use Only******

Vax Type	Vax Mfgr	Lot No	Exp Date	Dose (mL)	State Supplied	Preserv Free	Injection Route (Circle)	Injection Site (Circle)	Date On VIS	Date VIS Given 2015
☐ IIV4				0.50	Yes	Yes No	IM	R Arm L Arm	8/7/15	
☐ IIV3					Yes	Yes No	IM	R Arm L Arm	8/7/15	
☐ LAIV4				0.25	Yes	Yes	Intranasal		8/7/15	

Clinic Site Name/Address: Arlington Board of Health, 27 Maple Street, Arlington, MA 02476
MDPH Provider PIN#: 11828 **Vaccine Administrator Initials**: _____ **Date of Service**: _____/_____/2015

Please Turn Page

Seasonal Flu Vaccination for *Children* *(18 years and younger)*
2015-2016 Insurance Information Form

A. The following questions will determine if your child can receive the 2015-2016 Seasonal Flu Vaccine. Please mark YES or NO for each question.

If you answer "YES" to one or more of these questions, your child will not be able to receive the flu vaccine at this clinic. If you answer "NO" to the following questions, your child will receive the vaccine unless a concern arises following additional screening. If you are not sure of the answers to these questions, please check with your child's healthcare provider.

Information about the person receiving the vaccine:	**YES**	**NO**
1. Does your child have a serious allergy to eggs? *A serious allergy includes signs and symptoms similar to anaphylactic shock*	↑	↑
2. Does your child have a serious allergy to gentamicin, neomycin, polymixin or gelatin?	↑	↑
3. Has your child ever had a serious reaction to a previous dose of flu vaccine?	↑	↑
4. Has your ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	↑	↑

B. Your answers to the following questions help us determine which vaccine is best for your child.

Information about the person receiving the vaccine:	**YES**	**NO**
1. Does your child have any of the following: severe asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?	↑	↑
2. Is your child on long-term aspirin or aspirin-containing therapy (for example, do they take aspirin every day)?	↑	↑
3. Does your child have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?	↑	↑
4. Is there a possibility your child may be pregnant?	↑	↑
5. Will your child have close contact with a person who has a weakened immune system in the next 7 days (for example, someone who recently had a bone marrow transplant, cancer related treatments, or naturally occurring weakened immune system)?	↑	↑
6. Has your child taken anti-viral therapy (Tamiflu,Relenza, Rapivab) in the last 48 hours?		

Information about the person receiving the vaccine	**YES**	**NO**
Is your child allergic to latex?		
Is this your child's first time receiving the seasonal flu vaccine?		

*Providers are required by law to report your immunizations to the Massachusetts Immunization Information System (MIIS) (M.G.L c.111, Section 24M). For more information, please visit the MIIS website at www.mass.gov/dph/miis, or contact the Massachusetts Immunization Program directly at 617-983-6800 or 888-658-2850.

☐ I wish to opt out of the MIIS, which means my child's vaccination record will not be available to his/her PCP or other healthcare provider. I understand I need to complete an opt-out form. Call the Health Department at 781-316-3170 to request an opt out form or go to *http://www.mass.gov/eohhs/docs/dph/cdc/immunization/miis-objection-form.pdf* to download the form.

Please be sure to complete all of the information on the front side of this form. Thank you.